***Arkansas Central Cancer Registry* / Arkansas Department of Health**
Patient Reporting Form

Reporting Facility Name: _____ **Person completing Form:** _____

1. Name: _____
Last ***First*** ***Middle***

2. Address: _____ 3. Gender**:** ***Male*** ***Female***
Street ***City*** ***State*** ***Zipcode***

4. DOB: (mm/dd/yyyy) _____ 5. Social Security #_____ 6. Phone number: ( )_____-_____

7. Occupation:_____ 8. Race**: white Af. Am. Hispanic Other (please specify)** _____

9. Primary Payer **(circle one)**: ***com/private Medicare w/supple Medicare w/o supple Medicaid Self pay Not insured Unknown***

10. Tobacco Use**:** ***yes no past unk*** 11. Alcohol Use**:** ***yes no past unk*** *12.* Family Hx of cancer***: yes No Unk***

13. Is this a new cancer or a recurrence of a previously diagnosed cancer? (**Check one**) ***New*** ____ ***Recurrence*** ____

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14. Procedures Performed: (If you attach pathology report, leave this section blank)
Biopsy: _____ FNA: _____ BM Asp: _____ Date of Procedure: _____

Surgical Procedure Type: _____ Date of Procedure: _____

15. Primary Cancer site: _____ 16. Diagnosis Date _____ 17. Paired Organ **(left/right/bilateral)**: _____

18. Tumor Size: _____ 19. Histology **(cell type)**:_____

20. Grade(circle one):**well, moderate or poorly differentiated** 21. Lymph nodes removed (# positive / # removed**):** _____

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22. Pre op Tumor Markers **(circle one and add value)** Prostate (PSA/PAP) _____ Breast (ERA/PRA) _____/_____
Liver (AFP)_____ Colon (CEA) _____ Ovary (CA-125) _____ Testis (AFP/hCG) _____/_____/_____

23: Staging procedures: (attach copies of reports)

CXR ___ Date: _____ MRI ___ Date: _____ EGD ____ Date: _____
Positive Negative Unknown *Positive Negative Unknown* *Positive Negative Unknown*

Colonoscopy ___ Date: _____ Bone Scan ___ Date: _____ Mammogram ___ Date: _____
Positive Negative Unknown ***Positive Negative Unknown*** ***Positive Negative Unknown***

CT Scan Chest ____ Date: _____ CT Abd/Pelvis _____ Date: _____ Radiograph (Other):____Date:_____
Positive Negative Unknown ***Positive Negative Unknown*** ***positive Negative Unknown***

24. Distant metastasis ____ ____ ____ ***Use these codes for distant metastasis***
0 - none, 1 - peritoneum, 2 - lung, 3 - Pleura, 4 – liver, 5 - bone, 6 - central nervous system, 7 – skin, 8 – lymph nodes (distant)
9 – other, generalized, carcinomatosis, disseminated, not specified, unknown

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25. Has the patient had any of the following treatments? Where performed? _____

Chemotherapy: Yes/No Start Date:_____ Agent(s): _____

Hormone Treatment: Yes/No Start Date:_____ Type:_____

Radiation Therapy: Yes/No Start Date:_____ Stop Date:_____

Radiation Modality **(circle one)**: External beam / Photons / Electrons / stereotactic / Gamma Knife / Brachytherapy / Combination / Unknown

Radiation Dose (cGY):_____ Radiation Boost Dose (cGY) :_____

Other Treatment **(please specify):**_____
26. Physician Responsible for Ongoing Therapy/Care: _____27. Date last contact: _____
28. Patient Status **(circle one)** : Alive, free of cancer Alive, evidence of cancer Alive, cancer status unknown
Deceased, free of cancer Deceased, evidence of cancer Deceased, cancer status unknown
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